TRICARE DISENROLLMENT APPLICATION

This form is for eligible beneficiaries whose enrollment in TRICARE Prime, TRICARE Prime Remote, or US Family Health Plan is voluntary.

GENERAL INSTRUCTIONS:

1. Print all information in ink. Make sure the information is complete and accurate.

2. Ensure personal information matches information in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense Manpower Data Center (DMDC)Support Office at 1-800-538-9552 or refer to your name as printed on your ID card. The mailing address and telephone numbers you include on this form will update DEERS.

3. Sign and date the application (Section III).

4. Please keep a copy of the completed application for your records.

5. For TRICARE Prime and TRICARE Prime Remote disenrollments, submit your completed disenrollment application to the TRICARE contractor in your area or the TRICARE Service Center. For US Family Health plan see number 8 below.

   [Contractor's Name]
   [Street Address]
   [City, State 99999-9999]

6. For information on TRICARE, visit the TRICARE Website at www.tricare.osd.mil.

7. For information on TRICARE, please call 1-888-DoD-LIFE or 1-888- 363-5433.

8. For US Family Health Plan disenrollments, submit your completed disenrollment application to the US Family Health Plan facility where you are currently enrolled.

   [Contractor's Name]
   [Street Address]
   [City, State 99999-9999]

9. For information on US Family Health Plan, visit the US Family Health Plan Website at www.usfhp.org

10. For information on US Family Health Plan, please call [1-800-XXX-XXXX].

AGENCY DISCLOSURE STATEMENT

Public reporting burden for this collection of information is estimated to average five (5) minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0008), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR DISENROLLMENT APPLICATION TO THE ADDRESSES ABOVE. SEND YOUR DISENROLLMENT APPLICATION TO THE ADDRESS SHOWN ON THE DISENROLLMENT APPLICATION INSTRUCTION SHEET.

PRIVACY ACT STATEMENT

(1) Authority: 5 USC 552a, 10 U.S.C. 1079 and 1086, 58 FR 45318, 65 FR 30966, May 15, 2000.
(2) Purpose: To implement disenrollment from TRICARE Prime, TRICARE Prime Remote or the Uniformed Services Family Health Plan as requested by the enrollee.
(3) Uses: Information from disenrollment application and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions. Appropriate disclosures may be made to other federal, state, local and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program.
(4) Disclosure: Voluntary; however, failure to provide information will result in continued enrollment and responsibility for payment of an enrollment fee.

TRICARE DISENROLLMENT APPLICATION

(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)

SECTION I - SPONSOR INFORMATION (Must be completed on all applications)

SPONSOR INFO

1. Sponsor Social Security Number (SSN) _ _

2. Sponsor Name (Last, First, Middle Initial)

3. Date of Birth (YYYYMMDD))

SECTION II: INDIVIDUAL(S) REQUESTING DISENROLLMENT

1.

INDIVIDUAL DISENROLLMENT

a. Name (Last, First, Middle Initial)

b. Date of Birth (YYYYMMDD))

c. Relationship to Sponsor ☐ Self ☐ Retiree ☐ Spouse ☐ Former Spouse ☐ Child

d. Reason for Disenrollment (Check one)

☐	Moved	☐	Loss of TRICARE eligibility	☐	Loss of Prime eligibility due to turning 65 years of age (Prime only)
☐	Death	☐	Other Health Insurance	☐	Request for Voluntary Disenrollment
☐	Other *(Explain):*				

e. Requested Disenrollment Date (YYYYMMDD):

f. Telephone Number (Include Area Code) Home: ( ) Work ( )

2.

INDIVIDUAL DISENROLLMENT

a. Name (Last, First, Middle Initial)

b. Date of Birth (YYYYMMDD)

c. Relationship to Sponsor ☐ Self ☐ Retiree ☐ Spouse ☐ Former Spouse ☐ Child

d. Reason for Disenrollment (Check one)

☐	Moved	☐	Loss of TRICARE eligibility	☐	Loss of Prime eligibility due to turning 65 years of age (Prime only)
☐	Death	☐	Other Health Insurance	☐	Request for Voluntary Disenrollment
☐	Other *(Explain):*				

e. Requested Disenrollment Date (YYYYMMDD):

f. Telephone Number (Include Area Code) Home: ( ) Work ( )

3.

INDIVIDUAL DISENROLLMENT

a. Name (Last, First, Middle Initial)

b. Date of Birth (YYYYMMDD)

c. Relationship to Sponsor ☐ Self ☐ Retiree ☐ Spouse ☐ Former Spouse ☐ Child

d. Reason for Disenrollment (Check one)

☐	Moved	☐	Loss of TRICARE eligibility	☐	Loss of Prime eligibility due to turning 65 years of age (Prime only)
☐	Death	☐	Other Health Insurance	☐	Request for Voluntary Disenrollment
☐	Other *(Explain):*				

e. Requested Disenrollment Date (YYYYMMDD):

f. Telephone Number (Include Area Code) Home: ( ) Work ( )

SECTION III -- SIGNATURE

By signing this form, I certify that the information on this form is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments or concealment of a material fact may be subject to fine and imprisonment under applicable Federal law.

_____ _____

Signature Date Signed